

an intermediary for that OPO or laboratory.

(2) The interim rate will be based on the average cost per service incurred by an OPO or laboratory, during its previous fiscal year, associated with procuring a kidney for transplantation. This interim rate may be adjusted if necessary for anticipated cost changes. If there is not adequate cost data to determine the initial interim rate, it will be determined according to the OPO's or laboratory's estimate of its projected costs for the fiscal year.

(3) Payments made on the basis of the interim rate will be reconciled directly with the OPO or laboratory after the close of its fiscal year, in accordance with paragraph (e) of this section.

(4) Information on the interim rate for all freestanding OPOs and histocompatibility laboratories shall be disseminated to all transplant hospitals and intermediaries.

(e) *Retroactive adjustment.* (1) *Cost reports.* Information provided in cost reports by freestanding OPOs and histocompatibility laboratories must meet the requirements for cost data and cost finding specified in paragraphs (a) through (e) of § 413.24. These cost reports must provide a complete accounting of the cost incurred by the agency or laboratory in providing covered services, the total number of Medicare beneficiaries who received those services, and any other data necessary to enable the intermediary to make a determination of the reasonable cost of covered services provided to Medicare beneficiaries.

(2) *Audit and adjustment.* A cost report submitted by a freestanding OPO or histocompatibility laboratory will be reviewed by the intermediary and a new interim reimbursement rate for the succeeding fiscal year will be established based upon this review. A retroactive adjustment in the amount paid under the interim rate will be made in accordance with § 413.64(f). If the determination of reasonable cost reveals an overpayment or underpayment resulting from the interim reimbursement rate paid to transplant hospitals, a lump sum adjustment will be made directly between the intermediary and the OPO or laboratory.

(f) For services furnished on or after April 1, 1988, no payment may be made for services furnished by an OPO that does not meet the requirements of part 485, subpart D of this chapter.

(g) *Appeals.* Any OPO or histocompatibility laboratory that disagrees with an intermediary's cost determination under this section is entitled to an intermediary hearing, in accordance with the procedures contained in §§ 405.1811 through 405.1833, if the amount in controversy is \$1,000 or more.

[53 FR 6548, Mar. 1, 1988; 53 FR 9145, Mar. 21, 1988; 53 FR 18987, May 26, 1988]

**§ 413.179 Organ procurement organizations' (OPOs') or transplant centers' costs for kidneys sent to foreign countries or transplanted in patients other than Medicare beneficiaries.**

An OPO's or transplant center's total costs for all kidneys is reduced by the costs associated with procuring kidneys sent to foreign transplant centers or transplanted in patients other than Medicare beneficiaries. OPOs, as defined in § 485.302 of this chapter, must separate costs for procuring kidneys that are sent to foreign transplant centers and kidneys transplanted in patients other than Medicare beneficiaries from Medicare allowable costs prior to final settlement by the Medicare fiscal intermediaries. Medicare costs are based on the ratio of the number of usable kidneys transplanted into Medicare beneficiaries to the total number of usable kidneys applied to reasonable costs. Certain long-standing arrangements that existed before March 3, 1988 (for example, an OPO that procures kidneys at a military renal transplant hospital for transplant at that hospital), will be deemed to be Medicare kidneys for cost reporting statistical purposes. The OPO must submit a request to the fiscal intermediary for review and approval of these arrangements.

[54 FR 5623, Feb. 6, 1989]

**Subpart I—Prospectively Determined Payment Rates for Skilled Nursing Facilities**

SOURCE: 60 FR 37594, July 21, 1995, unless otherwise noted.

**§ 413.300 Basis and scope.**

(a) *Basis.* This subpart implements section 1888(d) of the Act, which provides for optional prospectively determined payment rates for qualified SNFs.

(b) *Scope.* This subpart sets forth the eligibility criteria an SNF must meet to qualify, the process governing election of prospectively determined payment rates, and the basis and methodology for determining prospectively determined payment rates.

**§ 413.302 Definitions.**

For purposes of this subpart—

*Area wage level* means the average wage per hour for all classifications of employees as reported by health care facilities within a specified area.

*Census region* means one of the 9 census divisions, comprising the 50 States and the District of Columbia, established by the Bureau of the Census for statistical and reporting purposes.

*Routine capital-related costs* means the capital-related costs, allowable for Medicare purposes (as described in Subpart G of this Part), that are allocated to the SNF participating inpatient routine service cost center as reported on the Medicare cost report.

*Routine operating costs* means the cost of regular room, dietary, and nursing services, and minor medical and surgical supplies for which a separate charge is not customarily made. It does not include the costs of ancillary services, capital-related costs, or, where appropriate, return on equity.

*Rural area* means any area outside an urban area in a census region.

*Urban area* means a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Office of Management and Budget, or a New England county deemed to be an urban area, as listed in § 412.62(f)(1)(ii)(B) of this chapter.

**§ 413.304 Eligibility for prospectively determined payment rates.**

(a) *General rule.* An SNF is eligible to receive a prospectively determined payment rate for a cost reporting period if it had fewer than 1,500 Medicare covered inpatient days as reported on a Medicare cost report in its immediately preceding cost reporting period. This criterion applies even if the SNF received a prospectively determined payment rate during the preceding cost reporting period.

(b) *Less than a full cost reporting period.* If the cost reporting period that precedes an SNF's request for prospectively determined payment is not a full cost reporting period, the SNF is eligible to receive prospectively determined payment rates only if the average daily Medicare census for the period (Medicare inpatient days divided by the total number of days in the cost reporting period) is not greater than 4.1.

(c) *Newly-participating SNFs.* An SNF is eligible to receive prospectively determined payment rates for its first cost reporting period for which it is approved to participate in Medicare.

**§ 413.308 Rules governing election of prospectively determined payment rates.**

(a) *Requirements.* An SNF must notify its intermediary at least 30 calendar days before the beginning of the cost reporting period for which it requests to receive such payment that it elects prospectively determined payment rates. A separate request must be made for each cost reporting period for which an SNF seeks prospectively determined payment. A newly participating SNF with no preceding cost reporting period must make its election within 30 days of its notification of approval to participate in Medicare.

(b) *Intermediary notice.* After evaluating an SNF's request for prospectively determined payment rates, the intermediary notifies the SNF in writing as to whether the SNF meets any of the eligibility criteria described in § 413.304 and the timely election requirements under § 413.308(a). The intermediary must notify the SNF of its initial and final determinations within 10 working days after it receives